John Elias Baldacci
Governor

John R. Nicholas
Commissioner

Maine Department of Health and Human Services
11 State House Station
Augusta, Maine 04333-0011
Bureau of Medical Services

August 31, 2004

TO: Interested Parties

FROM: Christine Zukas-Lessard, Acting Director, Bureau of Medical Services

SUBJECT: Proposed Rules: 10-144 Chapter 101, MaineCare Benefits Manual (MBM), Chapter II, Section 60, Medical Supplies and Durable and Medical Equipment.

This proposed rule establishes limitations of one pair of orthotic shoes and one pair of inserts per member per year, clearly identifies certain orthotics and prosthetics as noncovered luxury items, establishes clearer guidelines for determining eligibility for power wheelchairs and establishes guidelines for replacement of certain items of durable and medical equipment.

Should special accommodations at the scheduled hearing or a copy of the proposed rule be needed please call (207) 287-9368 or TTY (207) 287-1828 (Deaf/Hard of Hearing) or TTY 1-800-423-4331 (Deaf/Hard of Hearing) so accommodations can be made.

Rules and related rulemaking documents may be reviewed at and printed from the Bureau of Medical Services website at http://www.maine.gov/bms/MaineCareBenefitManualRules.htm or, for a fee, interested parties may request a paper copy of rules by contacting (207) 287-9368 or TTY: (207) 287-1828 or 1-800-423-4331.

Bureau of Medical Services
442 Civic Center Drive
Augusta, Maine 04333-0011

(207) 287-9368
Fax: (207) 287-9369
TTY: (207) 287-1828

Notice of Agency Rule-Making - Proposal

Agency: Department of Health and Human Services, Bureau of Medical Services

Chapter Number And Title 10-144 Chapter 101, MaineCare Benefits Manual (MBM), Chapter II, Section 60, Medical Supplies and Durable and Medical Equipment.

Proposed rule number: (assigned by secretary of state)

Concise Summary:

This proposed rule establishes limitations of one pair of orthotic shoes and one pair of inserts per member per year, clearly identifies certain orthotics and prosthetics as noncovered luxury items, establishes clearer guidelines for determining eligibility for power wheelchairs and establishes guidelines for replacement of certain items of durable and medical equipment.

See http://www.maine.gov/bms/MaineCareBenefitManualRules.htm **for rules and related rulemaking documents**.

This rule will ☐ will not ☒ have a fiscal impact on municipalities

Statutory Authority: 22 M.R.S.A., § 42, § 3173 , § 3174-FF

Public Hearing: Date: September 21, 2004, 12 noon

Location: Conference Room

Department of Health and Human Services
442 Civic Center Drive
Augusta, ME 04333-0011

Deadline for Comments: October 2, 2004

Agency Contact Person: Greg Nadeau

Agency : Bureau of Medical Services
Division of Policy and Provider Services
442 Civic Center Drive
11 State House Station
Augusta, ME 04333-0011

Telephone: (207) 287-9367 FAX: (207) 287-9369

TTY: 1-800-423-4331 or (207) 287-1828 (Deaf/Hard of Hearing)

Please approve bottom portion of this form and assign appropriate MFASIS number

Approved for payment _____ **Date:** _____

Authorized Signature

FUND: 013 **AGENCY:** 10A **ORG:** 3010 **APP:** 012 **JOB:** **OBJT:** **AMOUNT:**

SECTION 60 **MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT** 6/1/85

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SECTION 60 **MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT** 6/1/85

60.01 DEFINITIONS

Providers of medical supplies and durable medical equipment (DME) under a ~~Medicaid~~MaineCare Provider/Supplier Agreement with the ~~Department of Human Services~~Department of Health and Human Services will be reimbursed for services as specified below.

All enrolled ~~Maine Medicaid~~MaineCare providers of medical supplies and durable medical equipment must have a store with a commercial address for the sales and service of the supplies and equipment sold, rented or otherwise provided to members and must have regularly staffed operating hours. Hours must be posted in a visible location for the general public. The storefront must be located in Maine, within 15 miles of the Maine border in New Hampshire, or within 5 miles of the Maine border in Canada. The provider cannot be solely a sales representative for a manufacturer. The following exceptions apply:

1. DME and supplies provided to a member who is residing out of state, only for the purposes of meeting an emergency medical need, with prior authorization, at the discretion of the Department, taking into account cost effectiveness and medical necessity and only if the item(s) cannot be supplied by a MaineCare enrolled provider;

2. A provider who is the sole provider of a type of cost-effective, medically necessary durable medical equipment may be enrolled only for the purpose of providing that item with prior authorization. The provider must warranty the item;

3. The Department reserves the right to issue a request for proposals ~~(RFP)~~ for provision of any supply or piece of equipment. The resulting contract may be awarded to an out of state provider.

   All providers reimbursed under this Section are required to adhere to the policies and procedures outlined under the contract for purchased supplies and/or equipment, and from the supplier under contract. Reimbursement will not be made when purchased from another supplier. Providers will be notified of supplies and/or equipment that must be provided under an existing contract. All providers reimbursed under this Section will be notified of the procedures to follow when purchasing items from such contractor(s).

60.01-1 Medical Supplies are those medical supplies that are primarily needed to relieve or control a medical condition. Examples of supplies not primarily needed to relieve or control a medical condition include room and underarm deodorants.

60.01-2 Durable Medical Equipment is:

1. Equipment that can withstand repeated use;
2. Primarily used to serve a medical purpose and is medically necessary and reasonable for the treatment of the member's illness or injury or to improve an altered body function. Examples of items that are not primarily used for medical purposes include air conditioners, pools and exercise equipment.
3. Not generally useful to a person in the absence of illness or injury; and
4. Appropriate for use in the home and is in safe and reasonably good condition and suitable for its intended use.

SECTION 60 **MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT** 6/1/85

60.01 **DEFINITIONS** (cont.)

All four (4) of the criteria must be met for reimbursement.

Home/Environmental modifications do not meet the definition of medical supplies or durable medical equipment and are not covered under this Section. These items include but are not limited to ramps or structural or other changes to a building, to allow for access, support of equipment, or to attach equipment.

For specific definitions and criteria please refer to the Appendix to this Section.

60.02 **ELIGIBILITY FOR CARE**

Individuals must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

60.03 **DURATION OF CARE**

Each Title XIX and XXI member is eligible for as many covered services as are medically necessary and subject to limitations within this Section. The Department reserves the right to request additional information to determine medical necessity or expected therapeutic benefit of prescribed supplies or equipment.

60.04 **COVERED SERVICES**

A covered service is a service or item for which payment can be made by the Department and which meets one of the definitions listed in Section 60.01 and any other limitations described in this Section. The following sections describe covered medical supplies and durable medical equipment.

The provider of medical supplies and/or durable medical equipment shall inform MaineCare members prior to the provision of any medical supply or DME that is not or may not be MaineCare covered that the member will be responsible for payment. The provider shall document in the member's record that he or she was informed when services were not MaineCare covered in accordance with Chapter I of the MaineCare Benefits Manual.

60.04-1 Supplies which may be provided to members living in their own homes;

Covered medical supplies may be provided to members living in their own homes, when prescribed by a physician or primary care provider (PCP) (as defined in Chapter VI, Section 1) and meeting Department criteria as defined in Section 60.01.

Any medical supply having an adjusted acquisition cost (refer to Section 60~~.08~~.09) exceeding $499.99 may be reimbursed by MaineCare with prior authorization ~~prior to provision~~ (~~APTP~~PA) if the item is prescribed by a physician or PCP, and it is the most cost-effective item available that meets the medical needs of the member. The Department reserves the right to require an evaluation by professionals of its choice before granting ~~APTP~~PA. All medical supplies provided shall meet the conditions defined in Section 60.01.

60.04 **COVERED SERVICES** (cont.)

This Section does not apply to members in nursing facilities (NFs) or ICFs-MR (refer to Sections 60.04-3 & 60.04-4.)

Providers may not bill for routine medical supplies essential for the home health agency to carry out the physician's plan of care for individuals receiving home health services (see Section 40).

Post-surgical supplies will be provided as long as medically necessary as certified by the physician. Providers may not dispense more than a thirty-four (34) day supply at a time.

~~APTP~~PA is required for a medical supply when adjusted acquisition cost exceeds $499.99. All ~~enteral or~~ pa<u>a</u>erent<u>er</u>~~t~~al supplies require ~~APTP~~PA. Any other supply billed under another code which contains the phrase "miscellaneous," "not otherwise specified" or "not otherwise classified" in its description requires ~~APTP~~PA when adjusted acquisition cost exceeds $99.99.

60.04-2 Durable medical equipment which may be provided to members living in their own homes;

Durable medical equipment may be provided to members living in their own homes, when prescribed by a physician or PCP and when it meets criteria outlined in this Section. This Section does not apply to members in nursing facilities (NF) or ICFs-MR (refer to Sections 60.04-3 & 60.04-4).

Any durable medical equipment having an adjusted acquisition cost exceeding $499.99 may be reimbursed by MaineCare with ~~APTP~~PA if the equipment is prescribed by a physician or PCP, is the most cost-effective equipment available, meets the medical needs of the member and meets the criteria in the definition in Section 60.01-2. When determining whether a piece of equipment meets the threshold requirement of having an adjusted acquisition cost above $499.99, the adjusted acquisition cost of **ALL** related pieces of equipment must be ~~summed~~ <u>added together and totaled</u> before applying the criterion. For example, the adjusted acquisition cost of a wheelchair must be considered to be the sum of the adjusted acquisition cost of each of its components, including but not limited to: foot plates, wheels, wheel rims, arm rests, arm troughs, etc. Should the need arise for an unanticipated component, that item MUST have ~~APTP~~PA, regardless of price.

The following exceptions apply:

A. Custom molded orthotic and prosthetic items always require ~~APTP~~PA.

B. ~~APTP~~PA is required for all rentals, except in emergency situations, (refer to Section 60~~.06~~.07-6.) Oxygen is considered a rental.

60.04 **COVERED SERVICES** (cont.)

C. All equipment billed under the Healthcare Common Procedure Coding System (HCPCS) code E1399 requires ~~APTP~~PA. Any other equipment billed under another code which contains the phrase “miscellaneous,” “accessories,” "not otherwise specified" or "not otherwise classified" in its description requires ~~APTP~~PA when adjusted acquisition cost exceeds $99.99.

D. An item related to a piece of equipment that was supplied previously that required ~~APTP~~PA. For example, a part related to a wheelchair which previously
required ~~APTP~~PA would also require prior authorization excluding items replaced when performing a repair under Section 60~~.06~~.07-8 or replaced under a warranty.

E. Seasonal affective disorder lamps. Such lamps will only be prior authorized with strong evidence of severe, depressive seasonal affective disorder and an appropriate accompanying diagnosis.

F. Electric wheelchairs must be prior authorized by MaineCare, whether or not the member is eligible for Medicare.

G. Medical equipment that is primarily used for purposes of restraint is not covered, including fully enclosed canopy beds. Items used for positioning that meet the definition of medical supplies or durable medical equipment are allowed.

H. All continuous airway pressure (CPAP) devices and all bi-level pressure capability respiratory assist (Bi-PAP) devices will be rented on a 3-month trial basis to determine appropriateness and member utilization.

The Department reserves the right to require an evaluation by professionals of its choice before granting ~~APTP~~PA. See 60~~.06~~.07-5 for procedure to request ~~APTP~~PA.

60.04-3 Supplies and equipment which may be provided to members in a NF or ICF-MR and billed by a DME supplier;

The following is a list of covered supplies and equipment which may be provided for members in a NF or an ICF-MR, and billed by a provider or pharmacy when they are prescribed by a physician or PCP and they meet criteria defined in Section 60.01-2. This list supercedes the lists in Section 50 and Section 67.

For purposes of reimbursement, an acute care general hospital affiliated with a nursing facility through the same corporate structure may be considered a supplier of these items and may bill in conformance with the policies set forth in the ICF-MR Services (Section 50) and NF Services (Section 67) sections of this Manual, as applicable. Hospitals that bill as a supplier or pharmacy must bill under the appropriate Section (Section 60 for durable medical equipment and supplies or Section 80 for pharmacy services).

60.04 **COVERED SERVICES** (cont.)

All prior authorization requirements in subsections 60.04-1 and 60.04-2 above apply.

1. Amputee kit
2. Apnea monitor, pneumograms and supplies necessary for its use
3. Battery charger
4. Braces
5. Colostomy bags and supplies
6. Compressor nebulizers (hand held)
7. Cushions, special (silicone, etc.)
8. Electrolarynx batteries
9. Ileostomy bags and supplies
10. Intermittent positive pressure breathing equipment (IPPB) and supplies
11. Medicated mist equipment
12. Nebulizer, ultrasonic
13. Orthotic devices, except for any device used for restraint
14. Oxygen except for emergency or prn use
15. Oxygen cannula and facemasks
16. Oxygen concentrators
17. Oxygen liberators
18. Prosthetic devices - not dental
19. Replacement parts for items on this list
20. Respirator
21. Respirator supplies
22. Shoes - orthopedic shoes/lifts made from a mold or cast or with brace attached. may be billed only by the orthotist or manufacturer (does not include diabetic shoes).
23. Shoes, diabetic
24. Shoes, with Dennis Brown bar
25. Slings, all types
26. Splints
27. Stockings, orthopedic, heavy surgical elastic
28. Supports (e.g., orthopedic corsets, cervical collars, etc.)
29. Wheelchairs, specially equipped only
30. Wheelchair batteries

The Department may require the service of a licensed occupational therapist, a licensed physical therapist, certified orthotist or prosthetist (American Board for Certification) or an accredited orthotist (Board for Orthotist Certification) before an orthotic or prosthetic device is prior authorized.

60.04-4 Supplies and equipment provided to members in a NF or ICF-MR as part of the regular rate of reimbursement

The following list is included for reference only. These items may not be billed by either the facility or supplier.

Facilities which serve a special group of the disabled are expected to furnish that equipment which is normally used in their care (e.g. children's wheelchairs) as a part of their reasonable cost.

SECTION 60 **MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT** 6/1/85

60.04 **COVERED SERVICES** (cont.)

1. Alcohol, swabs and rubbing
2. Analgesics, non-prescription: a) aspirin: plain, buffered and coated, suppositories. b) acetaminophen: tablets, liquids and suppositories.
3. Antacids, non-prescription: a) aluminum/magnesium hydroxide (ex. Maalox) b) Aluminum/magnesium hydroxide with simethicone (ex. Mylanta, Maalox Plus) c) Calcium carbonate tablets (ex. Tums) d) Calcium carbonate/ magnesium hydroxide tablets (ex. Rolaids).
4. Alternating pressure pads, air mattresses, "egg crate" mattresses, gel mattresses
5. Applicators
6. Bandages
7. Bandaids
8. Basins
9. Beds, standard hospital type, not therapy
10. Bed pans
11. Bed rails
12. Blood pressure equipment
13. Bottles, water
14. Canes
15. Calcium supplements, non-prescription (ex. Tums, Oscal).
16. Catheters
17. Catheter trays, disposable
18. Chairs, standard and geriatric
19. Combs
20. Commodes
21. Corner chair
22. Cotton
23. Cough syrup and expectorants, all non-prescription brands
24. Crutches
25. Cushions (e.g., comfort rings)
26. Dietary supplements
27. Disinfectants
28. Douche trays, disposable
29. Dressings
30. Enema equipment
31. Enteral feeding, supplies and equipment.
32. Facility deodorants
33. Gauze bandages, sterile or non-sterile
34. Glucometers
35. General service supplies such as administration of oxygen and related medications, hand feeding, incontinency care, tray service, and enemas
36. Gloves, sterile or non-sterile
37. Gowns
38. Ice bags
39. Incontinency supplies (full brief- all sizes; bedpad; undergarment liners, disposable or reusable; underpads)
40. Irrigation trays

60.04 **COVERED SERVICES** (cont.)

41. Laundry services, personal (including supplies and equipment)
42. Laxatives, non-prescription: Stool softeners (ex. Docusate sodium liquid or capsule). Bulk: (ex. Psyllium). Stimulants: (ex. Bisacodyl tablets and suppositories; docusate casanthranol, liquid and/or capsule). Enemas: (ex. Saline, phosphate types-except Fleets); oil retention. Misc.: milk of magnesia; glycerin suppositories; lactulose and analogs (when used as a laxative); mineral oil.
43. Lotions, emollient
44. Lubricants, skin, bath oil
45. Mats – ICF-MR only
46. Mouth wash
47. Ointments and creams, available over the counter, including petroleum jelly and hydrocortisone 0.5%
48. Ophthalmic lubricants, tears and ointments
49. Oxygen, for emergency and prn use only, including portable oxygen and equipment
50. Parenteral solutions, supplies and equipment
51. Pillows
52. Pitchers, water
53. Powders, medicated and baby
54. Prone boards
55. Restraints, poseys, thoracic chest supports, wedge pillows, etc.
56. Sand and water tables – ICF-MR only
57. Sensory stimulation materials– ICF-MR only
58. Shampoo, regular, medicated and no-tears baby shampoo
59. Sheepskin
60. Shower chairs
61. Soap, including hypoallergenic
62. Special dietary supplements
63. Specimen containers
64. Sterile I.V. or irrigation solution
65. Stethoscopes
66. Sunscreen
67. Supplies, non-prescription, necessary for the treatment for decubitis
68. Suture sets
69. Swabs, medicated or unmedicated
70. Syringes and needles
71. Tapes
72. Testing materials to be used by staff of facility, not to include materials normally included in psychometric testing – ICF-MR only
73. Thermometers
74. Tissues
75. Toothbrushes
76. Toothpaste
77. Towels, washcloths
78. Tongue depressors
79. Traction equipment

60.04 **COVERED SERVICES** (cont.)

80. Trapezes
81. Tub seats
82. Tubes, gavage, lavage, etc.
83. Underpads
84. Urinals
85. Urinary drainage equipment and supplies (disposable)
86. Velcro strips - ICF-MR only
87. Vestibular boards – ICF-MR only
88. Vitamins, non-prescription, all brands
89. Walkers
90. Wheelchairs, standard, including those with removable or adjustable arms and leg rests including elevators, pediatric, "hemi" chairs, reclining wheelchairs
91. Wipes, rectal medicated
93. Routine personal hygiene and grooming items to include, but not be limited to items for shaving, shampooing, bathing, nail clipping (unless specified as a covered service when performed by a podiatrist as covered under the MaineCare Benefits Manual), haircutting or the services of a barber when requested and paid for by the member.

Routine transportation of members or laboratory specimens to hospitals or doctors' offices is provided by the facility as part of the facility's reimbursement.

60.05 **RESTRICTED SERVICES**

Physicians may bill for those supplies needed to perform office procedures which are above and beyond what is usually included in a normal office visit. Reimbursement is made on the basis of acquisition cost only and will not include any additional markup. Physicians must bill under Chapter II, Section 90, Physician Services of the MaineCare Benefits Manual.

A physician may not be reimbursed for both prescribing and supplying durable medical equipment to the same member, unless the durable medical equipment is otherwise unobtainable or the item typically requires no maintenance or replacement during the period used by a member. If these circumstances do exist, reimbursement to the prescribing physician for also supplying an item shall be on the basis of the reasonable acquisition cost of the item to the physician. The prescribing provider must maintain a copy of the invoice to support such claims. In addition, this policy shall also apply to any entity in which the physician has direct or indirect proprietary interest. All transactions are subject to State and Federal restrictions regarding self-referral.

DME providers may not bill for items delivered to a member in a physician's or PCP's office.

60.06 **LIMITATIONS AND PARAMETERS**

A. The following limitations exist for members 21 years of age and older:

1. Items classified in the Ingenix Company publication, HCPCS Level II code book, as Orthotic Procedures under the category, Orthopedic Shoes, under the sub-headings, Inserts, Arch Support- Removable- Premolded, Shoe Modifications-Wedges or Shoe Modifications-Heels are limited to 2 units per member per year;

60.06 **LIMITATIONS AND PARAMETERS** (cont)

2. Items classified in the Ingenix Company publication, HCPCS Level II code book, as Orthotic Procedures under the category, Orthopedic Shoes, under the sub-heading Orthopedic Footwear including the word "shoes" are limited to one unit per year; all other items under this sub-heading are limited to 2 units per year;

3. Items classified in the Ingenix Company publication, HCPCS Level II code book, as Orthotic Procedures under the category, Orthopedic Shoes, under the sub-heading Shoe Modifications-Lifts, are limited to 8 units per member per year (units are 1 inch increments);

4. Items classified in the Ingenix Company publication, HCPCS Level II code book, as Medical and Surgical Supplies under the category, Diabetic Shoes, Fitting and Modifications are limited to 2 units per member per year;

5. Items classified in the Ingenix Company publication, HCPCS Level II code book, as Orthotic Procedures under the category, Orthopedic Shoes, under the sub-heading Abduction and Rotation Bars, excluding the words "abduction rotation bar" are limited to one unit per year;

Note: Limits for inserts lifts and supports are limited to a total of 1 per foot per year. Limits for shoes of all types are 1 shoe per foot per year.

6. Patient lift systems that include track(s) to go from one location to another within the home are not covered.

B. The following parameters will govern unless providers can document the need to exceed the established parameters. The Prior Authorization Unit will process requests for exceptions to these parameters:

1. Members will be limited to 1 power operated vehicle every 3 years and cannot upgrade to a power wheelchair until the 3 years have lapsed;

2. Members will be limited to 1 wheelchair every 5 years, including power wheelchairs;

3. Members will be limited to 1 hospital bed every 10 years;

4. Members will be limited to 1 mattress every 5 years;

5. Members entitled to a prosthetic device necessary to allow functional mobility and qualify for a wheelchair must sign a letter stating they are aware that they must choose between the prosthetic device or a wheelchair. A wheelchair will be provided in the interim on a rental basis for those members choosing a prosthetic device.

SECTION 60 **MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT** 6/1/85

60.0~~6~~7 POLICIES AND PROCEDURES

60.0~~6~~7-1 Requirements

Medical supplies and durable medical equipment must meet all of the following requirements:

A. Comply with the definitions in Section 60.01;

B. Be considered reasonable and necessary for the treatment of a member's physical illness or injury or to improve an altered body function, must be prescribed by a physician or PCP; and must meet the criteria in this Section;

C. Be provided to a member who is not a member in a hospital, unless necessary for transition to home (equipment and supplies must have prior authorization ~~prior to provision~~);

D. Have scientifically valid clinical evidence of their efficacy and not be considered investigational or experimental by the Department;

E. Be approved as defined by the Food and Drug Administration; and

F. Be provided by a MaineCare authorized provider of medical supplies and durable medical equipment who has a location where members can procure repairs and servicing of items with warranties and guarantees, or meet one of the exceptions outlined in Chapter II, Section 60.01.

60.0~~6~~7-2 Reasonable and Necessary for Treatment

All durable medical equipment shall be prescribed by and certified as medically necessary by the physician or PCP. The Department shall determine whether the durable medical equipment is reasonable for the course of treatment for equipment having an adjusted acquisition cost exceeding $499.99. In making such a determination, the following factors are to be considered:

1. The equipment is medically necessary and meets the criteria in this Section;

2. The equipment serves a different purpose than equipment already available to the member;

3. The equipment is not more costly than a medically appropriate and realistically feasible alternative pattern of care; ~~and~~

4. The cost of the item is not disproportionate to the therapeutic benefits which could be derived from use of the equipment;

5. No modifications to the home are necessary for use of the equipment. Home/Environmental modifications do not meet the definition of medical supplies or durable medical equipment and are not covered under this Section.

60.0~~6~~7**POLICIES AND PROCEDURES** (cont.)

These items include but are not limited to ramps, structural or other changes to a building, to allow for access or support of equipment or to attach the equipment~~.~~; and

6. Prior to provision, a written document must be submitted indicating, if applicable, the equipment can freely pass through all entryways without the need for modification. It is the responsibility of the provider to submit documentation indicating that necessary modifications or structural changes have occurred prior to the request for authorization. The provider may not bill the Department for modifications or structural changes, as they are not a MaineCare covered durable medical equipment service.

60.0~~6~~7-3 Aesthetic or Deluxe Equipment

Standard models that ~~which~~ are medically necessary and meet the intended purpose will be reimbursed ~~provided~~. Aesthetic or deluxe models or equipment and aesthetic or deluxe features are not reimbursable. Examples of non-reimbursable equipment and supplies include such items as: baskets on wheelchairs, ~~or~~ sports model wheelchairs, ~~,~~ HCPCS Level II L codes that contain the word microprocessor in the description or any piece of equipment or feature that goes beyond the restoration of a basic function.

Stair climbing or gyroscopically guided wheelchairs are considered to be deluxe in nature and are not covered.

The codes and items listed above are examples of those pieces of equipment that have been determined to be aesthetic or deluxe models or equipment and aesthetic or deluxe features and are not meant to be an all inclusive list.

MaineCare does not “pay toward” deluxe or aesthetic equipment or supplies or allow the member to pay the difference in cost.

60.0~~6~~7-4 Rental and/or Purchase

The decision to rent or purchase an item lies solely with the Department.

1. Rental

   a. Rental may be made for certain items at the discretion of the Department. (Note: See Section 60~~.06~~.07-2, Reasonable and Necessary for Treatment.)

   b. All rental equipment must receive ~~APTP~~PA except for specific emergency equipment. Please refer to Section 60~~.06~~.07-6 for the policy regarding emergency equipment.

      Refer to Section 60~~.06~~.07-5 for the procedure to request ~~APTP~~PA.

60.0~~6~~7 **POLICIES AND PROCEDURES** (cont.)

c. The Department decides when to purchase rented equipment if a member requires its use for an extended period of time. If the Department decides to purchase the rented equipment, half of the total rental paid to date will be applied to the MaineCare allowed purchase price, not to exceed one hundred and sixty percent (160%) of the purchase price.

d. Unless otherwise authorized under this Section, rental rates include the cost of servicing, repairs or other maintenance and includes replacement parts for defective equipment and disposable items.

e. All rented equipment must be clean and in proper working condition when delivered.

2. Outright Purchase of New Equipment

a. The Department may purchase outright any durable medical equipment if the member will be using it for an extended period of time. Once an item is purchased, it becomes the property of the member.

b. The Department reserves the right to purchase the necessary equipment at the lowest price available and to preferentially choose equipment that includes a warranty.

c. All purchased equipment must be new and unused, clean, in proper working condition, free from defects and meet all implied and expressed warranties.

3. Outright Purchase of Used Equipment

Used equipment will be reimbursed on a prorated basis using the remaining useful life of the equipment based on General Accounting.

Principles applied to the MaineCare rate of reimbursement. To qualify for payment, a~~n~~ prior authorization ~~prior to provision~~ form must be completed. Refer to Section 60.~~06~~.07-5 for procedure to request ~~APTP~~PA. To qualify for ~~APTP~~PA, information on the Request for ~~APTP~~PA (MA-56R) or the appropriate Certificate of Medical Necessity (CMN) must indicate that the same warranty is offered on used equipment as on new equipment. The equipment being reconditioned shall not exceed the expense for new equipment.

4. Delivery, Installation and Member Instructional Time

The maximum allowable fee for purchase or rental of equipment shall include the following:

60.0~~6~~7 **POLICIES AND PROCEDURES** (cont.)

a. Cost of delivery to the inside of the member's residence and, when appropriate, to the room in which the equipment will be used;

b. Assembly of parts, installation and set-up of the equipment or customized fitting; and

c. Instruction to the member or caregivers in the safe and proper use of the equipment or supplies sufficient to ensure that they have demonstrated they can provide necessary service and /or use of the equipment or supplies safely and properly and limitations on replacement.

60.0~~6~~7-5 Procedure to Request Prior Authorization

Certain supplies and equipment, as set forth in Section 60.04, require ~~APTP~~PA. Requests for ~~APTP~~PA must be made on form MA-56R or the appropriate Medicare CMN, and must be ~~cannot be~~ submitted and approved prior to ~~more than four (4) months after~~ the date of service. The CMN form must be completed in accordance with Medicare guidelines.

See Chapter l, Subsection 1.17 for information regarding incomplete requests.

The white copy of the completed form is sent to:

~~Professional Claims~~Prior Authorization ~~Review~~ Unit
Division of ~~Quality Improvement~~Health Care Management and Member Services
Bureau of Medical Services
11 State House Station
Augusta, Maine 04333-0011

The ~~Professional Claims Review~~Prior Authorization Unit staff will notify the provider and member of deferral, approval or denial. If approved, a prior authorization number will be designated in the approval letter.

In the case of motorized wheelchair requests for Medicare/MaineCare dually-eligible members, MaineCare shall issue a prior authorization decision and the allowable reimbursement rate. The prior authorization will be issued prior to the purchase of any electric wheelchair and prior to the submission of any claims to Medicare. Any price changes for electric wheelchairs which have received prior approval shall be treated in the same manner as all other price changes on prior authorized equipment.

Prior authorization requests inadequately documented will be deferred for a period of thirty (30) days pending submission of additional information. See Chapter l for further details regarding deferred requests and MaineCare reimbursement policy applicable to all providers. Proper documentation includes proof of acquisition cost or a price quote from a manufacturer. Claims for reimbursement must be made in

60.0~~6~~7 **POLICIES AND PROCEDURES** (cont.)

accordance with Section 60~~.09~~.10. If a claim is not equal to the exact amount of the prior authorization, a subsequent adjustment to the authorization may be made with appropriate documentation. Claims should not be submitted until the adjustment is made. Alternatively, the Department may choose to issue a letter approving the request for prior authorization without assigning an approved amount. Once documentation of actual acquisition cost is received from the provider an allowable amount will be assigned by MaineCare staff.

A completed Medicare CMN shall include itemized adjusted acquisition cost and usual and customary charges for the equipment being supplied.

The Department reserves the right to request detailed documentation including cost of materials, labor costs and total hours for the manufacture or fabrication of orthotic and prosthetic devices. This information may be estimated prior to the manufacture or fabrication, however actual costs must be submitted upon completion. Non-compliance may result in denial of payment or recoupment of payments.

60.0~~6~~7-6 Emergency Equipment

Standard equipment may be furnished on a rental basis in an emergency, without prior authorization.

The supplier must request prior authorization for emergency rental within thirty (30) days of providing the equipment or reimbursement will be denied. Should the need for the equipment exceed thirty (30) days the Department will, in all instances, pay the rental for the emergency period on covered equipment. If the decision is made not to purchase or continue the rental, a rental payment up to two (2) months will be made to the supplier. The decision to outright purchase, rent or deny authorization for the rental will be made by the end of the two (2) months.

If the decision is made to purchase, one-half of the rental fee will be applied to the purchase price.

60.0~~6~~7-7 Delivery of Equipment

The reimbursable cost includes delivery, installation and instruction on use of equipment.

60.0~~6~~7-8 Replacement Parts

~~APTP~~PA is required for any replacement parts over $499.99 to repair medically necessary equipment. ~~APTP~~PA is also required if replacement parts and labor combined exceed $499.99 to repair medically necessary equipment. See Section 60~~.06~~.07-5 above for procedure to request ~~APTP~~PA. Repairs to equipment with a total cost (parts and labor) exceeding sixty-five (65) percent of replacement cost requires ~~APTP~~PA, at which time the Department will decide if replacement is appropriate.

60.0~~6~~7 **POLICIES AND PROCEDURES** (cont.)

Repairs are allowed if they are necessary to make the equipment serviceable and if the cost of replacement parts and labor does not exceed sixty-five (65) percent of the estimated cost of replacing the equipment with a new item.

Warranties must be utilized by the provider prior to billing MaineCare.

60.0~~6~~7-9 Labor

Labor charges are reimbursable for repairs to outright purchased equipment only. Such charges are not reimbursed when the equipment has a current warranty. Labor charges are not reimbursed for evaluation, assembly, fitting or other installation.

~~APTP~~PA is required for labor charges over $499.99. ~~APTP~~PA is also required if labor and replacement parts combined exceed $499.99. In addition, ~~APTP~~PA is required when any item has been repaired three (3) times in any twelve (12) month period. The Department reserves the right to request documentation necessary to validate medical necessity before ~~APTP~~PA is granted. See Section 60~~.06~~.07-5 for procedure to request ~~APTP~~PA.

60.0~~6~~7-10 Replacement of Each Item

Replacement of equipment is allowed for the following reasons:

1. Irreparable damage or wear;

2. A change in the member's condition which requires a change of equipment. In such cases, the Department requires a current physician's or PCP's order documenting the need for the change; or

3. Repairing the item would cost more than sixty-five (65) percent of the replacement cost of the item.

Replacement will not be allowed in cases of malicious damages, culpable neglect, equipment that has been sold, given away, thrown out or wrongful disposition of equipment by the member or responsible party.

60.07-8 Prosthetics

Providers are responsible to warranty prosthetics for a period of one year to assure proper fit of products purchased by the Department. This will include adjustments, repairs and parts replacement associated with shrinkage, workmanship etc.

60.0~~7~~8 **SURVEILLANCE AND UTILIZATION REVIEW**

Surveillance and utilization review requirements are outlined in Chapter I of the MaineCare Benefits Manual.

60.0~~8~~9 **REIMBURSEMENT**

A. The amount of payment for medical supplies, durable medical equipment and service, except for orthotics and prosthetics, rentals and oxygen, shall be the lowest of:

1. The maximum MaineCare amount published at least annually on the Department's website, http://www.maine.gov/bms//dme_supply_codes.html, and made available to providers.

2. The adjusted acquisition cost (AC) plus the allowed 40% mark up of acquisition cost (AC*.4) not to exceed $2,000;

   Adjusted acquisition cost for purposes of this Section is the lowest price paid to a supplier by an eligible provider for durable medical equipment, medical/surgical supplies after adjustments for quantity discounts and excluding all associated costs, including but not limited to, shipping, freight, handling and insurance costs. Any prompt payment discount received by the provider shall not reduce the adjusted acquisition cost.

   The Department may at any time require proof of the acquisition cost to the eligible provider. Such proof shall be in the form of a receipted invoice from the seller.

3. The provider's usual and customary charge; or

4. The manufacturer's suggested retail price for any medical supply or durable medical equipment (including replacement parts).

B. The amount of payment for orthotics and prosthetics shall be 94% of the lowest of:

1. The maximum MaineCare amount published at least annually on the Department's website on the Department's website, http://www.maine.gov/bms//dme_supply_codes.html, and made available to providers;

2. The lowest amount paid by Medicare;

3. The provider's usual and customary charge; or

4. The manufacturer's suggested retail price (including replacement parts).

C. Rentals, except for oxygen, shall be reimbursed at a monthly rate equal to one-twelfth of the MaineCare allowable purchase price described in (A) above, for a period not to exceed 12 months.

D. Oxygen supplies and equipment are reimbursed using two different monthly rental rates, ~~equal to those paid by Medicare,~~ one for portable gas or liquid oxygen and one for concentrator or stationary liquid oxygen. The MaineCare amount will be published at least annually and made available to providers on the Department's website, http://www.maine.gov/bms//dme_supply_codes.html. Claims shall be submitted in accordance with billing instructions provided by the Department which include

60.0~~8~~9 **REIMBURSEMENT** (cont.)

information regarding appropriate codes to be used by providers when billing for these services. Oxygen requires annual prior authorization. The monthly rental rate is the lowest of:

1. The maximum MaineCare rental amount published at least annually on the Department's website and made available to providers;

2. The lowest rental amount paid by Medicare; or

3. The provider's usual and customary rental charge.

E. Any manufacturer's rebate shall be paid to the Treasurer, State of Maine. Providers shall forward or otherwise pay to the Treasurer of the State of Maine all manufacturers' rebates associated with durable medical equipment or medical supplies provided to members pursuant to this Section of the MaineCare Benefits Manual.

F. In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other resource that is available for payment of a rendered service prior to billing the MaineCare Program.

Special provisions apply for electric wheelchairs:

Providers must submit a request for reimbursement to Medicare Part B for the initial purchase of an electric wheelchair for those individuals who are eligible for reimbursement under that program:

1. The total payment will be no more than the established MaineCare allowance for electric wheelchairs;
2. The payment to the provider shall be reduced by any amounts paid by Medicare;
3. MaineCare's allowance in non-assigned cases shall not be limited by the Medicare determination of medical necessity or allowable reimbursement rate; and
4. Services initially prior authorized by MaineCare will reflect a reduction in reimbursement equal to the Medicare average payment. Subsequent adjustments will be authorized following a review of all Medicare Explanations of Benefits or written correspondence.

G. Payment by the Department for any good or service provided shall constitute full payment for the supplies or equipment furnished and no additional charge shall be made to, or on behalf of, the eligible member.

Note: MaineCare reimbursement rates can be found at the following website location: http://www.~~state.me.us~~maine.gov/bms/~~policy/dme_codes~~/dme_supply_codes.html or by calling the Bureau of Medical Services at (207) 287-9367, 1-800-321-5557 option 9, TTY (207) 287-3094 or 1(800) 423-4331 unless stated otherwise in these rules. Rates will be published at least annually and made available to providers.

60. ~~09~~10**COPAYMENT**

Copayment dispute resolution procedures are described in Chapter I of the MaineCare Benefits Manual.

60.~~09~~10**COPAYMENT** (cont)

60.~~09~~10-1 Copayment Amount

A. A copayment will be charged to each MaineCare member receiving items of equipment or supplies except for the amount of the copayment shall not exceed $3.00 per day for equipment or supplies, according to the following schedule:

MaineCare Payment for Service Member Copayment

$10.00 or less	$ .50
$10.01 - 25.00	$1.00
$25.01 - 50.00	$2.00
$50.01 or more	$3.00

B. The member shall be responsible for copayments up to $30.00 per month whether the copayment has been paid or not. After the $30.00 cap has been reached the member shall not be required to make additional copayments and the provider shall receive full MaineCare reimbursement.

C Members shall not be charged more than $3.00 per month for any rental service.

D. No provider may deny services to a member for failure to pay a copayment. Providers must rely upon the member's representation that he or she does not have the cash available to pay the copayment. A member's inability to pay a copayment does not, however, relieve him/her of liability for a copayment.

E. Providers are responsible for documenting the amount of copayments charged to each member (regardless of whether the member has made payment) and shall disclose that amount to other providers, as necessary, to confirm previous copayments.

60.~~09~~10-2 Copayment Exemptions:

No copayment may be imposed with respect to the following services:

A. All exemptions listed in Chapter I, Section 1~~.09~~.10-2; and

B. All oxygen and oxygen equipment services.

60.~~10~~.11**BILLING INSTRUCTIONS**

A. Providers must ~~B~~billing ~~must be accomplished~~ in accordance with the Department's "Billing Instructions for Medical Supplies and Durable Medical Equipment."

~~B. In order to receive full MaineCare payment for claims submitted for a service that is defined as an exemption in Chapter I, the diagnosis code "EMR" must be included in addition to the primary diagnosis code.~~

~~C~~B. All services provided on the same day shall be submitted on the same claim form for MaineCare reimbursement.

~~D~~C. All claims submitted must include a primary diagnosis code.

~~E~~D. Providers may not submit separate claims for components that are considered to be part of the initially authorized equipment.

~~F~~E. Providers may not bill more than a thirty-four (34) day supply at a time.

APPENDIX

Specific Definitions and Criteria for Durable Medical Equipment

A. The Department has adopted Medicare criteria as described below for the following equipment and supplies:

1. Oxygen (home use)
2. Power operated vehicles that may be appropriately used as wheelchairs (for additional MaineCare criteria see B. 8.)
3. Specialty sized wheelchairs (wheelchairs not meeting the definition of a standard wheelchair)
4. Seat lift mechanisms
5. Blood glucose monitors
6. Infusion pumps
7. Pneumatic compression devices
8. Continuous positive airway pressure devices
9. Hospital beds
10. Enteral and parenteral nutrition therapy
11. Cochlear implants

1. **Home use of oxygen**

a. General - Coverage of home oxygen and oxygen equipment is considered reasonable and necessary only for members with significant hypoxemia who meet the medical documentation, laboratory evidence, and health conditions specified in subsections b, c, and d. This section also includes special coverage criteria for portable oxygen systems.

b. Medical documentation - Initial claims for oxygen services must include a completed Form HCFA-484 (Certificate of Medical Necessity: Oxygen) or MA-56 to establish whether coverage criteria are met and to ensure that the oxygen services provided are consistent with the physician's or PCP's prescription or other medical documentation. The treating physician's or PCP's prescription or other medical documentation must indicate that other forms of treatment (e.g., medical and physical therapy directed at secretions, bronchospasm and infection) have been tried, have not been sufficiently successful, and oxygen therapy is still required. While there is no substitute for oxygen therapy, each member must receive optimum therapy before long-term home oxygen therapy is ordered. (See Medicare Carriers Manual §3312 for completion of Form HCFA-484.)

The medical and prescription information in section B of Form HCFA-484 can be completed only by the treating physician, the PCP, the physician's employee, or another clinician (e.g., nurse, respiratory

1. **Home use of oxygen** (cont.)

therapist, etc.) as long as that person is not the DME supplier. Although hospital discharge coordinators and medical social workers may assist in arranging for prescribed home oxygen, they do not have the authority to prescribe the services. Suppliers may not enter this information. While this section may be completed by a non-physician clinician or a physician employee, it must be reviewed and the form HCFA-484 signed by the attending physician or PCP. The prescription for home oxygen must be updated annually by the treating physician or PCP.

A physician's or PCP's certification of medical necessity for oxygen equipment must include the results of specific testing before coverage can be determined.

Claims for oxygen must also be supported by medical documentation in the member's record. This documentation may be in the form of a prescription written by the member's attending physician who has recently examined the member (normally within a month of the start of therapy) and must specify:

1. A diagnosis of the disease requiring home use of oxygen;
2. The oxygen flow rate; and
3. An estimate of the frequency, duration of use (e.g., 2 liters per minute, 10 minutes per hour, 12 hours per day), and duration of need (e.g., 6 months or lifetime).

NOTE: A prescription for "Oxygen PRN" or "Oxygen as needed" does not meet this last requirement. Neither provides any basis for determining if the amount of oxygen is reasonable and necessary for the member.

The attending physician or PCP specifies the type of oxygen delivery system to be used (i.e., gas, liquid, or concentrator) by signing the completed form HCFA-484. In addition, the supplier or prescriber may use the space in section C for written confirmation of additional details of the physician's or PCP's order. The additional order information contained in section C may include the means of oxygen delivery (mask, nasal, cannula, etc.), the specifics of varying flow rates, and/or the noncontinuous use of oxygen as appropriate. The prescriber confirms this order information with his or her signature in section D.

New medical documentation written by the member's attending physician or PCP must be submitted to the ~~Professional Claims Review~~Prior Authorization Unit in support of revised oxygen requirements when there has been a change in the member's condition and need for oxygen therapy exists.

The Department reserves the right to conduct periodic, continuing medical necessity reviews on members whose conditions warrant these reviews and on members with indefinite or extended periods of necessity.

1. **Home use of oxygen** (cont.)

The ~~Professional Claims Review~~Prior Authorization Unit may also request documentation of the results of a repeat arterial blood gas or oximetry study.

c. Laboratory Evidence-Initial claims for oxygen therapy must also include the results of a blood gas study that has been ordered and evaluated by the attending physician or PCP. This is usually in the form of a measurement of the partial pressure of oxygen (PO2) in arterial blood. A measurement of arterial oxygen saturation obtained by ear or pulse oximetry, however, is also acceptable when ordered and evaluated by the attending physician or PCP and performed under his or her supervision or when performed by a qualified provider or supplier of laboratory services. When the arterial blood gas and the oximetry studies are both used to document the need for home oxygen therapy and the results are conflicting, the arterial blood gas study is the preferred source of documenting medical need. A DME supplier is not considered a qualified provider or supplier of laboratory services for purposes of these requirements. This prohibition does not extend to the results of blood gas tests conducted by a hospital certified to do such tests. The conditions under which the laboratory tests are performed must be specified in writing and submitted with the request for prior authorization i.e., at rest, during exercise, or during sleep.

The preferred sources of laboratory evidence are an existing physician or PCP and/or hospital records that reflect the member's medical condition. If more than one arterial blood gas test is performed during the member's hospital stay, the test result obtained closest to, but no earlier than two (2) days prior to the hospital discharge date is required as evidence of the need for home oxygen therapy.

For those members whose initial oxygen prescription did not originate during a hospital stay, blood gas studies should be during a period of an acute illness or an exacerbation of their underlying disease.

The ~~Professional Claims Review~~Prior Authorization Unit may accept an attending physician's or PCP's statement of recent hospital test results for a particular member, when appropriate, in lieu of copies of actual hospital records.

A repeat arterial blood gas study is appropriate when evidence indicates that the member has undergone a major change in his or her condition relevant to home use of oxygen. If the Professional Claims

Review Unit has reason to believe that there has been a significant change in the member's physical condition, it may ask for documentation of the results of another blood gas or oximetry study.

1. **Home use of oxygen** (cont.)

d. Health Conditions-Coverage is available for members with significant hypoxemia in the chronic stable state if: (1) the attending physician or PCP has determined that the member has a health condition outlined in subsection (d)(i); the member meets the blood gas evidence requirements specified in subsection D.(iii); and (3) the member has appropriately tried other alternative treatment measures without complete success. (See subsection A (1)(b) of this Appendix.)

i. Conditions for Which Oxygen Therapy May Be Covered

a. A severe lung disease, such as chronic obstructive pulmonary disease, diffuse interstitial lung disease, whether of known or unknown etiology; cystic fibrosis bronchiectasis; widespread pulmonary neoplasm; or
b. Hypoxia-related symptoms or findings that might be expected to improve with oxygen therapy. Examples of these symptoms and findings are pulmonary hypertension, recurring congestive heart failure due to chronic cor pulmonale, erythrocytosis, impairment of the cognitive process, nocturnal restlessness, and morning headache.

ii. Conditions for Which Oxygen Therapy Is Not Covered

a. Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood, and there are other preferred treatments;
b. Breathlessness without cor pulmonale or evidence of hypoxemia. Although intermittent oxygen use is sometimes prescribed to relieve this condition, it is potentially harmful and psychologically addicting;
c. Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities. (There is no evidence that increased PO2 improves the oxygenation of tissues with impaired circulation); or
d. Terminal illnesses that do not affect the lungs.

iii. Covered Blood Gas Values-If the member has a condition specified in subsection A (1)(d)(i), the ~~Professional Claims Review~~Prior Authorization Unit must review the medical documentation and laboratory evidence that has been submitted for a particular member (see subsections A (1)(b) and (c)) and determine if coverage is available under one of the three group categories outlined below.

a. Group I-Except as modified in subsection A (1)(d), coverage is provided for members with significant hypoxemia evidenced by any of the following:

1. An arterial PO2 at or below 55 mm Hg (millimeters of mercury), or an arterial oxygen saturation at or below 88 percent, taken at rest, breathing room air.

1. **Home use of oxygen** (cont.)

2. An arterial PO2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, taken during sleep for a member who demonstrates an arterial PO2 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89 percent, while awake; or a greater than normal fall in oxygen level during sleep (a decrease in arterial PO2 more than 10 mm Hg, or decrease in arterial oxygen saturation more than 5 percent) associated with symptoms or signs reasonably attributable to hypoxemia (e.g., impairment of cognitive processes and nocturnal restlessness or insomnia). In either of these cases, coverage is provided only for use of oxygen during sleep, and then only one type of unit will be covered. Portable oxygen, therefore, would not be covered in this situation.
3. An arterial PO2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a member who demonstrates an arterial PO2 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89 percent, during the day while at rest. In this case, supplemental oxygen is provided for during exercise if there is evidence the use of oxygen improves the hypoxemia that was demonstrated during exercise when the member was breathing room air.

b. Group II-Except as modified in subsection A (1)(d), coverage is available for members whose arterial PO2 is 56-59 mm Hg or whose arterial blood oxygen saturation is 89 percent, if there is evidence of:

(1) Dependent edema suggesting congestive heart failure;
(2) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVFL); or
(3) Erythrocythemia with a hematocrit greater than 56 percent.

c. Group III-Except as modified in subsection A (1)(d), the provider must apply a rebuttable presumption that a home program of oxygen use is not medically necessary for members with arterial PO2 levels at or above 60 mm Hg, or arterial blood oxygen saturation at or above 90 percent. In order for claims in this category to be reimbursed, the ~~Professional Claims Review~~Prior Authorization Unit's reviewing professional needs to review any documentation submitted in rebuttal of this presumption and grant specific approval. The Department expects few requests to be approved for coverage in this category.

1. **Home use of oxygen** (cont.)

d. Variable Factors That May Affect Blood Gas Values-In reviewing the arterial PO2 levels and the arterial oxygen saturation percentages specified in subsections D. 3. a, b and c, variations in oxygen measurements that may result from such factors as the member's age, the altitude level, or the member's decreased oxygen carrying capacity may be considered.

e. Portable Oxygen Systems-A member meeting the requirements specified below may qualify for coverage of a portable oxygen system either (1) by itself or (2) to use in addition to a stationary oxygen system. A portable oxygen system is covered for a particular member if:

1. The request for ~~APTP~~PA meets the requirements specified in subsections A (1)(a) through (d), as appropriate; and
2. The medical documentation indicates that the member is mobile in the home and would benefit from the use of a portable oxygen system in the home. Portable oxygen systems are not covered for members who qualify for oxygen solely based on blood gas studies obtained during sleep.

2. **Power-operated vehicles (POV) ~~that may be used as wheelchairs~~**

Power-operated vehicles that may be appropriately used as wheelchairs are covered under this Section. They may be covered if a wheelchair is medically necessary and the member is unable to manually operate a wheelchair.

A specialist in physical medicine, orthopedic surgery, neurology, or rheumatology must provide an evaluation of the member's medical and physical condition and a prescription for the vehicle to assure that the member requires the vehicle and is capable of using it safely. The documentation should also include a statement indicating the member is able to transfer safely in and out of the POV, and has adequate trunk stability to safely ride in the POV. When the ~~Professional Claims Review~~Prior Authorization Unit determines that such a specialist is not reasonably accessible, e.g., more than one (1) day's round trip from the member's home, or the member's condition precludes such travel, a prescription from the member's physician or PCP is acceptable with the documentation described above completed by the member's physician. Further, the Department may request an evaluation by an occupational therapist and/or physical therapist in place of the previously listed specialists.

The ~~Professional Claims Review~~Prior Authorization Unit must prior authorize all power-operated vehicles, including the specialist's or other physician's or PCP's prescriptions and evaluations of the member's medical and physical conditions, to insure that all coverage requirements are met.

All criteria for a standard wheelchair must be met.

2. **Power-operated vehicles (POV)** ~~**that may be used as wheelchairs**~~ (cont.)

The following additional criteria must also be met:

The member is capable of safely operating the controls of the POV.

~~The member is primarily non-ambulatory and has severe weakness of the upper extremities due to a neurological or muscular disease or condition.~~

The member is unable to functionally operate a wheelchair manually.

The member must have a letter from his or her physician stating that the member's condition is not expected to deteriorate significantly for 3 years.

Prior to provision, a written document must be submitted indicating the equipment can freely pass through all entry ways without the need for modification. It is the responsibility of the provider to submit documentation indicating that necessary modifications or structural changes have occurred prior to the request for authorization. The provider may not bill the Department for modifications or structural changes, as they are not a MaineCare covered durable medical equipment service.

In a NF or other setting in which there is continuous supervision, the requesting provider will need to document the member's medical necessity to be independently mobile beyond what can be provided by staff in that setting when requesting prior authorization for a POV.

A POV will be denied as not medically necessary when it is needed primarily for use outside the home.

A POV will be denied as not medically necessary when it is primarily used to allow a member to perform leisure or recreational activities.

A POV that is generally intended for outdoor use because of size or features is not covered.

If a member-owned POV meets coverage criteria, medically necessary replacement items, including but not limited to batteries, are covered.

The Medicare allowance for a POV includes all options and accessories that are provided at the time of initial issue, including but not limited to batteries, battery charger, seating systems, etc.

3. **Specially sized wheelchairs**

Payment may be made for a specially sized wheelchair even though it is more expensive than a standard wheelchair when special circumstances warrant that payment. For example, a narrow wheelchair may be required because of the narrow doorways of a member's home or because of a member's slender build. Such difference in the size of the wheelchair from the standard model is not considered a deluxe feature.

3. **Specially sized wheelchairs** (cont)

A physician's or PCP's certification or prescription that a special size is needed is not required when it be can determined from the information on file or other sources that a specially-sized wheelchair (rather than a standard one) is needed to accommodate the wheelchair to the place of use or the physical size of the member.

In addition, all criteria for a standard wheelchair must be met.

Prior to provision, a written document must be submitted indicating the equipment can freely pass through all entry ways without the need for modification. It is the responsibility of the provider to submit documentation indicating that necessary modifications or structural changes have occurred prior to the request for authorization. The provider may not bill the Department for modifications or structural changes, as they are not a MaineCare covered durable medical equipment service.

4. **Seat lift mechanism**

Reimbursement may be made for the rental or purchase of a medically necessary seat lift mechanism when prescribed by a physician or PCP for a member with severe arthritis of the hip or knee and members with muscular dystrophy or other neuromuscular diseases, when it has been determined the member can benefit therapeutically from use of the device. In establishing medical necessity for the seat lift mechanism, the evidence must show that the item is included in the physician's or PCP's course of treatment, that it is likely to effect improvement, or arrest or retard deterioration in the member's condition, and that the severity of the condition is such that the alternative would be chair or bed confinement.

Coverage of seat lift mechanisms is limited to those types which operate smoothly, can be controlled by the member, and effectively assist a member in standing up and sitting down without other assistance. Excluded from coverage is the type of lift which operates by a spring release mechanism with a sudden, catapult-like motion and jolts the member from a seated to a standing position. The payment for units which incorporate a recliner feature along with the seat lift mechanism is limited to the amount payable for a seat lift mechanism without this feature.

5. **Home blood glucose monitors**

There are several different types of blood glucose monitors which use reflectance meters to determine blood glucose levels. Coverage of these devices varies, both with respect to the type of device and the medical condition of the member for whom the device is prescribed.

Reflectance colorimeter devices used for measuring blood glucose levels in clinical settings are not covered as durable medical equipment for use in the home because their need for frequent professional recalibration makes them unsuitable for home use. However, some types of blood glucose monitors which use a reflectance meter specifically designed for home use by diabetic members may be covered as durable medical equipment, subject to the conditions and limitations described below.

a. Blood glucose monitors are meter devices which read color changes produced on specially treated reagent strips by glucose concentrations in the member's

5. **Home blood glucose monitors** (cont.)

blood. The member, using a disposable sterile lancet, draws a drop of blood, places it on a reagent strip and, following instructions which may vary with the device used, inserts it into the device to obtain a reading. Lancets, reagent strips, and other supplies necessary for the proper functioning of the device are also covered for members for whom the device is indicated. Home blood glucose monitors enable certain members to better control their blood glucose levels by frequently checking and appropriately contacting their physician or PCP for advice and treatment. Studies indicate that the member's ability to carefully follow proper procedures is critical to obtaining satisfactory results with these devices. In addition, the cost of the devices, with their supplies, limits economical use to members who must make frequent checks of their blood glucose levels. Accordingly, coverage of home blood glucose monitors is limited to members meeting the following conditions:

i. The member must be diagnosed as a Type l or Type ll diabetic;
ii. The member's physician or PCP states that the member is capable of being trained to use the particular device prescribed in an appropriate manner. In some cases, the member may not be able to perform this function, but a responsible individual can be trained to use the equipment and monitor the member to assure that the intended effect is achieved. This is permissible if the record is properly documented by the member's physician or PCP; and
iii. The device is designed for home rather than clinical use.

b. There is also a blood glucose monitoring system designed especially for use by those with visual impairments. The monitors used in such systems are identical in terms of reliability and sensitivity to the standard blood glucose monitors described above. They differ by having such features as voice synthesizers, automatic timers, and specially designed arrangements of supplies and materials to enable the visually impaired to use the equipment without assistance.

These special blood glucose monitoring systems are covered if the following conditions are met:

i. The member and device meet the four conditions listed above for coverage of standard home blood glucose monitors; and
ii. The member's physician or PCP certifies that he or she has a visual impairment severe enough to require use of this special monitoring system.

6. **Infusion pumps**

Infusion pumps are covered when the following indications for treatment are present:

A. External Infusion Pumps

1. Iron Poisoning: When used in the administration of deferoxamine for the treatment of acute iron poisoning and iron overload, only external infusion pumps are covered.

6. **Infusion pumps** (cont.)

2. Thromboembolic Disease: When used in the administration of heparin for the treatment of thromboembolic disease and/or pulmonary embolism, only external infusion pumps used in an institutional setting are covered.

3. Chemotherapy for Liver Cancer: The external chemotherapy infusion pump is covered when used in the treatment of primary hepatocellular carcinoma or colorectal cancer where this disease is unresectable or where the member refuses surgical excision of the tumor.
4. Morphine for Intractable Cancer Pain: Morphine infusion via an external infusion pump is covered when used in the treatment of intractable pain caused by cancer.
5. Continuous subcutaneous insulin infusion pumps (CSII) An external infusion pump and related drugs/supplies will be covered as medically necessary in the home setting in the following situation: Treatment of Type I diabetes.

   In order to be covered, members must meet criterion (a) or (b):

   a. The member has completed a comprehensive diabetes education program, and has been on a program of multiple daily injections of insulin (i.e. at least 3 injections per day), with frequent self-adjustments of insulin dose for at least 6 months prior to initiation of the insulin pump, and has documented frequency of glucose self-testing an average of at least 4 times per day during the 2 months prior to initiation of the insulin pump, and meets one or more of the following criteria while on the multiple daily injection regimen:

      i. Glycosylated hemoglobin level(HbAlc) > 7.0%
      ii. History of recurring hypoglycemia
      iii. Wide fluctuations in blood glucose before mealtime
      iv. Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl
      v. History of severe glycemic excursions

   b. The member with Type I diabetes has been on a pump prior to enrollment and has documented frequency of glucose self-testing an average of at least 4 times per day during the month prior enrollment.

   Type I diabetes needs to be documented by a fasting C-peptide level < = 110% of the lower limit of normal of the laboratory's measurement method.

   Continued coverage of the insulin pump would require that the member has been seen and evaluated by the treating physician or PCP at least every 3 months. The pump must be ordered by, and follow-up care of the member must be managed by, a physician or PCP who manages multiple members with CSII and who works closely with a team including nurses, diabetes educators, and dietitians who are knowledgeable in the use of CSII.

6. **Infusion pumps** (cont.)

Subcutaneous insulin infusion pumps will continue to be denied as not medically necessary and reasonable for all Type II diabetics including insulin-requiring Type II diabetics.

Insulin syringe filling devices for the visually impaired (e.g. Count-a-dose) are covered with adequate documentation maintained demonstrating visual impairment.

6. Other uses of external infusion pumps are covered if the ~~Professional Claims Review~~Prior Authorization Unit verifies the appropriateness of the therapy and of the prescribed pump for the individual member.

NOTE: Payment may also be made to the appropriate provider for drugs necessary for the effective use of an external infusion pump as long as the drug being used with the pump is itself reasonable and necessary for the member's treatment.

B. Implantable Infusion Pumps

1. Chemotherapy for Liver Cancer-The implantable infusion pump is covered for intra-arterial infusion of 5-FUdR for the treatment of liver cancer for members with primary hepatocellular carcinoma or Duke's Class D colorectal cancer, in whom the metastases are limited to the liver, and where (1) the disease is unresectable or (2) where the member refuses surgical excision of the tumor.

2. Anti-Spasmodic Drugs for Severe Spasticity-An implantable infusion pump is covered when used to administer anti-spasmodic drugs intrathecally (e.g., baclofen) to treat chronic intractable spasticity in members who have proven unresponsive to less invasive medical therapy as determined by the following criteria:

As indicated by at least a 6-week trial, the member cannot be maintained on noninvasive methods of spasm control, such as oral anti-spasmodic drugs, either because these methods fail to control adequately the spasticity or produce intolerable side effects, and prior to pump implantation, the member must have responded favorably to a trial intrathecal dose of the anti-spasmodic drug.

3. Opioid Drugs for Treatment of Chronic Intractable Pain-An implantable infusion pump is covered when used to administer opioid drugs (e.g., morphine) intrathecally or epidurally for treatment of severe chronic intractable pain of malignant or nonmalignant origin in members who have a life expectancy of at least three (3) months and who have proven unresponsive to less invasive medical therapy as determined by the following criteria:

6. **Infusion pumps** (cont.)

The member's history must indicate that he/she would not respond adequately to non-invasive methods of pain control, such as systemic opioids (including attempts to eliminate physical and behavioral abnormalities which may cause an exaggerated reaction to pain); and a preliminary trial of intraspinal opioid drug administration must be undertaken with a temporary intrathecal/epidural catheter to substantiate adequately acceptable pain relief and degree of side effects (including effects on the activities of daily living) and member acceptance.

4. Coverage of Other Uses of Implanted Infusion Pumps--Determinations may be made on coverage of other uses of implanted infusion pumps if documentation is provided that allows the ~~Professional Claims Review~~Prior Authorization Unit to verify that: The drug is reasonable and necessary for the treatment of the individual member; it is medically necessary that the drug be administered by an implanted infusion pump; and the FDA approved labeling for the pump must specify that the drug being administered and the purpose for which it is administered is an indicated use for the pump. Providers must submit documentation to determine reasonableness and medical necessity.

5. Implantation of Infusion Pump Is Contraindicated-The implantation of an infusion pump is contraindicated in the following members:

i. Members with a known allergy or hypersensitivity to the drug being used (e.g., oral baclofen, morphine, etc.);
ii. Members who have an infection;
iii. Members whose body size is insufficient to support the weight and bulk of the device; and members with other implanted programmable devices since crosstalk between devices may inadvertently change the prescription.
iv. Thromboembolic Disease: According to the Public Health Service, there is insufficient published clinical data to support the safety and effectiveness of the heparin implantable pump. Therefore, the use of an implantable infusion pump for infusion of heparin in the treatment of recurrent thromboembolic disease is not covered.
v. Diabetes: Implanted infusion pumps for the infusion of insulin to treat diabetes is not covered. The data do not demonstrate that the pump provides effective administration of insulin.

Pneumatic compression devices consist of an inflatable garment for the arm or leg and an electrical pneumatic pump that fills the garment with compressed air. The garment is intermittently inflated and deflated with cycle times and pressures that vary among devices. Pneumatic devices are covered for the treatment of lymphedema or for the treatment of chronic venous insufficiency with venous stasis ulcers.

7. **Pneumatic compression devices (used for lymphedema)**

Lymphedema is the swelling of subcutaneous tissues due to the accumulation of excessive lymph fluid. The accumulation of lymph fluid results from an impairment to the normal clearing function of the lymphatic system and/or from an excessive production of lymph. Lymphedema is divided into two broad classes according to etiology. Primary lymphedema is a relatively uncommon, chronic condition which may be due such causes as Milroy's Disease and congenital anomalies. Secondary lympphedema, which is much more common, results from the destruction of or damage to formerly functioning lymphatic channels, such as surgical removal of lymph nodes or post radiation fibrosis, among other causes.

Pneumatic compression devices are covered in the home setting for the treatment of lymphedema if the patient has undergone a four-week trial of conservative therapy and the treating physician determines that there has been no significant improvement or if significant symptoms remain after the trial. The trial of conservative therapy must include use of an appropriate compression bandage system or compression garment, exercise and elevation of the limb. The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression.

Chronic Venous Insufficiency with venous stasis ulcers

Chronic Venous Insufficiency (CVI) of the lower extremities is a condition caused by abnormalities of the venous wall and valves, leading to obstruction or reflux of blood flow in the veins. Signs of CVI include hyperpigmentation, stasis dermatitis, chronic edema and venous ulcers. Pneumatic compression devices are covered in the home setting for the treatment of CVI of the lower extremities only if the patient has one or more venous stasis ulcer(s) which have failed to heal after a 6 month trial of conservative therapy directed by the treating physician. The trial of conservative therapy must include a compression bandage system or compression garment, appropriate dressings for the wound, exercise, and elevation of the limb.

General coverage criteria

Pneumatic compression devices are covered only when prescribed by a physician and when they are used with appropriate physician oversight, i.e., physician evaluation of the patient’s condition to determine medical necessity of the device, assuring suitable instruction in the operation of the machine, a treatment plan defining the pressure to be used and the frequency and duration of use and ongoing monitoring of use and response to treatment.

8. **Continuous positive airway pressure (CPAP) and bi-level positive airway pressure (Bi-PAP)**

CPAP/ Bi-PAP are a non-invasive techniques for providing low levels of air pressure from a flow generator, via a nose mask, through the nares. The purpose is to prevent the collapse of the oropharyngeal walls and the obstruction of airflow during sleep, which occurs in obstructive sleep apnea (OSA).

8. **Continuous positive airway pressure (CPAP) and bi-level positive airway pressure (Bi-PAP)** (cont)

The use of CPAP/ Bi-PAP devices is covered when ordered and prescribed by the licensed treating physician to be used in adult patients with OSA if either of the following criteria using the Apnea-Hypopnea Index (AHI) are met:

AHI = 15 events per hour, or

AHI =5 and =14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia or documented hypertension, ischemic heart disease or history of stroke.

The AHI is equal to the average number of episodes of apnea and hypopnea per hour and must be based on a minimum of two hours of sleep recorded by polysomnography using actual recorded hours of sleep (i.e. the AHI may not be extrapolated or projected).

All continuous airway pressure (CPAP) devices and all bi-level pressure capability respiratory assist (Bi-PAP) devices will be rented on a 3-month trial basis to determine if the equipment and treatment will continue. Determining factors shall be based on but not limited to:

The 3 month rental period will be reviewed to determine the utilization of the equipment, member comfort level with the ongoing use of equipment and the success of the equipment to decide if the purchase, continued rental or change in equipment is warranted. The Department requires documentation in support of any or all of the above to continue treatment beyond the 3 month rental period.

9. **Hospital beds**

A. General Requirements for Coverage of Hospital Beds-- A physician's or PCP's prescription, and such additional documentation as the ~~Professional Claims Review~~Prior Authorization Unit may consider necessary, including medical records, physician's and PCP's reports, must establish the medical necessity for a hospital bed due to one of the following reasons:

1. The member's condition requires positioning of the body; e.g., to alleviate pain, promote good body alignment, prevent contractures, avoid respiratory infections, in ways not feasible in an ordinary bed; or
2. The member's condition requires special attachments that cannot be fixed and used on an ordinary bed.

B. Physician's or PCP's Prescription--The physician's or PCP's prescription, which must accompany the request for prior authorization, and supplementing documentation when required, must establish that a hospital bed is medically necessary. If the stated reason for the need for a hospital bed is the member's condition requires positioning, the prescription or other documentation must describe the medical condition, e.g., cardiac disease, chronic obstructive pulmonary disease, quadriplegia or paraplegia, and also the severity and frequency of the symptoms of the condition, that necessitates a hospital bed for positioning.

9. **Hospital beds** (cont.)

If the stated reason for requiring a hospital bed is the member's condition requires special attachments to a bed, the prescription must describe the member's condition and specify the attachments that require a hospital bed.

C. Variable Height Feature--In well documented cases, the ~~Professional Claims Review~~Prior Authorization Unit may determine that a variable height feature of a hospital bed, approved for coverage under subsection A above, is medically necessary and, therefore, covered, for one of the following conditions:

Severe arthritis and other injuries to lower extremities; e.g., fractured hip. The condition requires the variable height feature to assist the member to ambulate by enabling the member to place his or her feet on the floor while sitting on the edge of the bed;

Severe cardiac conditions. For those cardiac members who are able to leave bed, but who must avoid the strain of "jumping" up or down;

Spinal cord injuries, including quadriplegia and paraplegia members, multiple limb amputees and members who have suffered a stroke. For those members who are able to transfer from bed to a wheelchair, with or without help; or

Other severely debilitating diseases and conditions, if the variable height feature is required to assist the member to ambulate.

D. Electric Powered Hospital Bed Adjustments--Electric powered adjustments to lower and raise head and foot may be covered when the ~~Professional Claims Review~~Prior Authorization Unit determines that the member's condition requires frequent change in body position and/or there may be an immediate need for a change in body position (i.e., no delay can be tolerated) and the member can operate the controls and cause the adjustments. Exceptions may be made to this last requirement in cases of spinal cord injury and members with brain damage.

E. Side Rails--If the member's condition requires bed side rails, they may be covered when an integral part of, or an accessory to, a hospital bed.

10. **Enteral and parenteral nutritional therapy**

There are members who, because of chronic illness or trauma, cannot be sustained through oral feeding. They must rely on either enteral or parenteral nutritional therapy, depending upon the particular nature of their medical condition.

Coverage of nutritional therapy requires that the member must have an inoperative internal body organ or function thereof.

If the coverage requirements for enteral or parenteral nutritional therapy are met, related supplies, equipment and nutrients are also covered under the conditions in the following paragraphs.

10. **Enteral and parenteral nutritional therapy** (cont)

1. Parenteral Nutrition Therapy-Daily parenteral nutrition is considered reasonable and necessary for a member with severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member's general condition.

Since the alimentary tract of such a member does not function adequately, an indwelling catheter is placed percutaneously in the subclavian vein and then advanced into the superior vena cava where intravenous infusion of nutrients is given for part of the day. The catheter is then plugged by the member until the next infusion. Following a period of hospitalization, which is required to initiate parenteral nutrition and to train the member in catheter care, solution preparation, and infusion technique, the parenteral nutrition can be provided safely and effectively in the member's home.

For parenteral nutrition therapy to be covered, the provider’s records must contain a physician’s or PCP’s written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements of the prosthetic device benefit are met and that parenteral nutrition therapy is medically necessary. An example of a condition that typically qualifies for coverage is a massive small bowel resection resulting in severe nutritional deficiency in spite of adequate oral intake. If the claim involves an infusion pump, sufficient evidence must be maintained to support a determination of medical necessity for the pump. Providers must bill for pumps based on the reasonable charge for the simplest model that meets the medical needs of the member as established by medical documentation.

Nutrient solutions for parenteral therapy are routinely covered for no more than one month's supply of nutrients at any one time. Payment for the nutrients is based on the reasonable charge for the solution components unless the medical record, including a signed statement from the attending physician or PCP, establishes that the beneficiary, due to his/her physical or mental state, is unable to safely or effectively mix the solution and there is no family member or other person who can do so. Payment will be on the basis of the reasonable charge for more expensive pre-mixed solutions only under the latter circumstances.

2. Enteral Nutrition Therapy--Enteral nutrition is considered reasonable and necessary for a member with a functioning gastrointestinal tract who, due to pathology to or nonfunction of the structures that normally permit food to reach the digestive tract, cannot maintain weight and strength commensurate with his or her general condition. Enteral therapy may be given by nasogastric, jejunostomy, or gastrostomy tubes and can be provided safely and effectively in the home.

Typical examples of conditions that qualify for coverage are head and neck cancer with reconstructive surgery and central nervous system disease leading to interference with the neuromuscular mechanisms of ingestion of such severity that the beneficiary cannot be maintained with oral feeding. The

10. **Enteral and parenteral nutritional therapy**

provider's records must contain a physician's or PCP's written order or prescription and sufficient medical documentation (e.g., hospital records, clinical findings from the attending physician or PCP) to permit an independent conclusion that the member's condition meets the requirements of the prosthetic device benefit and that enteral nutrition therapy is medically necessary and are to be reviewed at periodic intervals and additional medical documentation considered necessary is to be obtained as part of this review. Reimbursement is limited to no more than one month's supply of enteral nutrients at any one time.

If the claim involves a pump, sufficient medical documentation must be maintained by the provider to establish that the pump is medically necessary, i.e., gravity feeding is not satisfactory due to aspiration, diarrhea, dumping syndrome. Payment for the pump is based on the reasonable charge for the simplest model that meets the medical needs of the member as established by medical documentation.

The Department will accept the appropriate Medicare Certificate of Medical Necessity (CMN) in place of the MA-56R. The CMN form must be completed in accordance with Medicare guidelines.

11. **Cochlear Implant Device**

A cochlear implant device is an electronic instrument, part of which is implanted surgically to stimulate auditory nerve fibers, and part of which is worn or carried by the individual to capture, analyze and code sound. Cochlear implant devices are available in single channel and multi-channel models. The purpose of implanting the device is to provide an awareness and identification of sounds and to facilitate communication for persons who are profoundly hearing impaired.

MaineCare coverage is provided only for those members who meet all of the following selection guidelines.

A. General
   1) Diagnosis of bilateral severe-to-profound sensorineural hearing impairment with limited benefit from appropriate hearing (or vibrotactile) aids;
   2) Cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation;
   3) Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system;
   4) No contraindications to surgery; and
   5) The device must be used in accordance with the FDA-approved labeling.

B. Adults.--Cochlear implants may be covered for adults (over age 18) for prelinguistically, perilinguistically, and postlinguistically deafened adults. Postlinguistically deafened adults must demonstrate test scores of 30 percent or less on sentence recognition scores from tape recorded tests in the member's best listening condition.

B. MaineCare criteria for the following equipment and supplies:

1. **Orthotics & Prosthetics**

The Department requires that orthotic or prosthetic services be provided by a licensed occupational therapist, a licensed physical therapist, certified orthotist or prosthetist (American Board for Certification) or an accredited orthotist (Board for Orthotist Certification) when an orthotic or prosthetic device is prior authorized.

a. Orthotic Device: A mechanical device which is intended and fashioned to support or correct any defect or deformity or to improve the function of movable parts of the body and generally known as a "brace" or "orthosis." The orthotic device must be specifically ordered by a physician or PCP and may not be standard equipment used by the general population.

b. Prosthetic device: An artificial substitute for a missing body part (i.e., arm, leg, eye), not including dentures.

~~APTP~~PA is required for all custom molded orthotics and prosthetics regardless of price. Custom fitted orthotics and prosthetics in excess of $499.99 require ~~APTP~~PA. ~~Shoe inserts will be reimbursed for no more than two pair every six months.~~

2. **Intermittent Positive Pressure Breathing (IPPB) Equipment**

IPPB equipment requires prior authorization which will be granted only when a need is documented by a physician or PCP.

3. **Standard Wheelchair**

A standard wheelchair is one that would generally satisfy the needs of all members. It is fabricated to withstand normal usage and body weight and has brakes and armrests. A wheelchair having any of the following features may be considered standard.

a. Eight inch casters
b. Sling seat
c. Foot plates (including adjustable foot plates)
d. Capable of being easily folded as a complete unit without removing integral parts.

Regardless of the type, only one wheelchair at a time is reimbursable for each member.

Reimbursement is allowed for amputee kits for standard wheelchairs in a NF or ICF-MR and will allow a wheelchair with right or left-handed drive in case of arm amputee or paralysis.

Reclining wheelchairs are not medically necessary if sought only for positioning.

3. **Standard Wheelchair**

A tilt-in-space wheelchair is not the same as a reclining wheelchair.

Criteria:

The member's condition is such that without use of a wheelchair the member would otherwise be bed or chair confined.

The primary purpose is not to allow the member to perform leisure or recreational activities.

Payment is made for only one wheelchair at a time.

A member's residence must be handicapped accessible to meet the needs of the equipment being requested as Home/Environmental modifications are not covered.

4. **Criteria for Augmentative Communication Device/System**

a. Definition

An augmentative communication device/system is a total functional communication system of an individual including a communicative technique, a symbol set or system and communication/interaction behavior. The augmentative communication system encompasses all techniques which aid communication with some type of physical object or device. These include methods that use communication boards, charts, and mechanical or electrical aids, or computerized devices. The purpose of augmentative communication device systems is to enhance communication skills and interaction behavior that are necessary to have an idea expressed and understood.

The device is designed to meet the individual needs of the member. The augmentative communication device/system may include spoken and or printed words as output, pictures, symbols, traditional orthography (written) and sign language. The augmentative communication device/system is complex and, therefore, must be coordinated with an overall plan of service.

This plan shall identify and assess the physical, cognitive, intellectual, linguistic, sensory, and communication needs of the individual. Both short and long-term management plans shall be developed.

The following criteria need to be met during the life of the plan: The establishment of a monitoring mechanism to ensure cost containment and accountability; the maintenance of equipment; and the identification of advocates to promote the access and continuity of these services.

4. **Criteria for Augmentative Communication Device/System** (cont.)

b. Coverage

i. Coverage for an augmentative communication device/system shall be based on communication necessity that is determined by the nature and severity of the individual's expressive communication disorder. The determination for coverage shall be based upon an overall plan of care established by a physician or PCP. The plan of care must identify and assess the environmental, physical, cognitive, intellectual, linguistic, sensory, and communication needs of the individual. The Department reserves the right to request an evaluation from another physician or PCP, and may require that the physician be board certified as a neurologist, physiatrist, or ear, nose and throat specialist. In addition, the Department may request an evaluation from an audiologist,

ii. In order to assure that there is a full and adequate augmentative communication assessment and management of the individual with a severe expressive communication disorder, a referral must be made to a licensed speech-language pathologist who is familiar with augmentative communication device/systems. The evaluation/ assessment performed by the licensed speech-language pathologist will include but is not limited to the following criteria:

1) language comprehension;
2) expressive language capabilities;
3) oral motor speech status;
4) the appropriate symbol set or system;
5) the member's use of pragmatics in communication and assessment of communicative interest;
6) communication needs including the need to enhance conversation, writing and signaling emergency, basic care and related needs and writing impairments; and
7) the member's environment.

The speech-language pathologist shall identify what other augmentative communication device systems have been evaluated and tested and shall select the augmentative communication device/system needed by the member. The appropriate device is based on a medical rationale for the request of a particular device, and on a comparative analysis of equipment available and the member's ability to use the equipment. The pathologist shall provide a written plan for review, monitoring, and maintenance of the communicator. A speech-language pathologist shall re-evaluate the member's need as part of a request for replacement or improvement of an augmentative communication device/system.

4. **Criteria for Augmentative Communication Device/System** (cont.)

The Department may request a second opinion from another speech-language pathologist.

iiie. In addition to the referral to a licensed speech-language pathologist, an evaluation by an occupational therapist or a physical therapist is required.

1) Occupational therapist registered. An occupational therapist must be licensed as such in the state or province in which services are provided.;
2) Physical therapist. A physical therapist must be licensed as such in the state or province in which services are provided.

The evaluation performed by the occupational therapist registered or physical therapist shall include an assessment of the member's motor skills and the member's physical ability to relate to the augmentative communication device/system. The assessment shall also identify the member's mobility status and the optimum seating and physical positioning of the member.

The Department may request an evaluation by a licensed psychologist. If an evaluation is requested, it shall include an assessment of the member's cognitive abilities by a psychologist who is skilled in evaluating people who are non-speaking.

The periodicity of re-evaluation will be established by the speech-language pathologist with input from the member, family, and/or caregivers as appropriate. Changes in technology alone do not necessitate replacement or upgrades in equipment.

Purchase or Rental Arrangements

The Department reserves the right to purchase or rent all augmentative communication device systems.

Prior to purchase, rental or lease arrangements the review by the licensed speech-language pathologist must be consistent with the physician’s or PCP’s overall plan of care. The review must include a statement by the speech-language pathologist of the member's progress, prognosis, and continued plan of care, as well as provide instruction to the person, as needed, to maximize his or her communication skills with the particular augmentative communication device.

4. **Criteria for Augmentative Communication Device/System** (cont.)

c. Prior Authorization ~~Prior to Provision~~

All of the following information must be documented for prior authorization ~~prior to provision~~ by the member's physician or PCP:

~~a~~i. Name, birth date, MaineCare ID number;
~~b~~ii. Written referral from a physician or PCP to a licensed speech-language pathologist who has demonstrated expertise with augmentative communication device systems;
~~c~~iii. Physical assessment of any hearing or visual loss, muscular disorder, or motor weaknesses to include motor speech problems, people who have had laryngectomies or glossectomies (removal of the tongue), people with missing limbs, aphasia, and head injuries or any other physical disability;
~~d~~iv. Current intellectual/communication level;
~~e~~v. Current cognitive level;
~~f~~vi. Status of current speech/language treatment; and
~~g~~vii. A copy of the warranty of the equipment, a statement identifying the availability of maintenance and a statement of the acquisition cost of the equipment.

The Department reserves the right to request a second opinion covering communicative necessity of prescribed equipment on any request for prior authorization ~~prior to provision~~ for an augmentative communication device/system.

The Department will approve an augmentative communication device/system based only on communicative necessity.

5. **Criteria for Home Traction**

a. The member must have an orthopedic impairment which requires traction equipment which prevents ambulation during the period of use and must meet the following:

~~1~~i. The member has failed to respond to routine physical therapy, and

~~2~~ii. Travel to a facility to receive physical therapy is detrimental to the member's physical health. This must be verified by a physical therapist or a physician or PCP.

b. The supplier shall provide the following services which are included in the reimbursement for traction:

~~1~~i. Set-up of traction equipment
~~2~~ii. Training of member or caregiver; and
~~3~~iii. Maintenance of equipment

6. **Criteria for Bone Growth Stimulator**

A bone growth stimulator is covered when there is a nonunion of a long bone fracture or failed fusion. The physician or PCP must document the date of the injury, the dates of medical and surgical treatment and the expected outcome of the devices. Prior ~~A~~authorization ~~prior to provision~~ is required.

7. **Criteria for Apnea Monitor**

An apnea monitor is considered necessary for infants if any of the following is present:

a. An infant who has a severe apparent life threatening episode (ALTE) that required mouth-to-mouth resuscitation or vigorous stimulation.
b. Any pre-term infant who has had an episode of apnea.
c. Any infant who has had a sibling who has died of sudden infant death syndrome.
d. A diagnosis of central hypoventilation, gastroesophageal reflux.
e. Any infant with a tracheotomy.
f. Any infant whose mother used cocaine or opiates during pregnancy.
g. Any infant whose mother is a multiparous adolescent.

8. **Additional MaineCare Criteria for Power Wheelchairs**

When evaluating the need for a power wheelchair the Department reserves the right to request a second opinion of its choice from an occupational therapist, physical therapist, physiatrist, physician or PCP concerning medical necessity of the prescribed equipment for any request for prior authorization ~~prior to provision~~ for a power wheelchair. An itemized list of all necessary parts and adjusted acquisition cost and usual and customary price shall be provided to the Department, as well as documented medical evidence justifying the need for the prescribed equipment. Reimbursement will not be allowed for repairs or replacement parts for any equipment under warranty.

8. **Additional MaineCare Criteria for Power Wheelchairs**

The Department will not approve equipment except for medical necessity. (Example: Vocational, job or college related needs do not meet the criteria for medical necessity.)

Conditions not meeting the criteria outlined in the Appendix will be evaluated on a case-by-case basis. Providers should submit all of the listed material and documentation in addition to any other relevant information that may assist in the evaluation and determination. In addition to meeting all of the criteria in Section 2 of the appendix the following additional criteria must also be met.

A motorized or powered wheelchair is considered medically necessary for individuals who lack the capacity to ambulate a sufficient distance to accomplish essential activities of daily living within the home; defined as inability to ambulate at least 100 feet. MaineCare does not consider inability to climb stairs a medically necessary indication for an electric, motorized or power wheelchair. An electric

8. **Additional MaineCare Criteria for Power Wheelchairs**

wheelchair is not considered medically necessary to elevate a person to eye level or to extend a wheelchair bound person’s reach. In addition, inability to navigate rough terrain outside the home is not considered a medically necessary indication for an electric wheelchair.

In a NF or other setting in which there is continuous supervision, the requesting provider will need to document the member's medical necessity to be independently mobile beyond what can be provided by staff in that setting when requesting prior authorization for a power wheelchair.